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TO DOCTOR

Address

THE BEARER

(Insert Name of Doctor)

(Insert Name of Doctor)

(Insert Name of Jujured employee)

Claims that he was injured

(Date)

Please random received.

Please render necessary treatment and report his condition to Claim Dept., EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN on "Surgeon's or Physician's First Report" form.

If injury is not one covered under the Workmen's Compensation Law, liability is limited to payment for first examination,

(Name of Employer)

(Street and Number)

(City)

(State)

(State)

NOTICE TO EMPLOYER

Forward "Employer's First Report" to company immediately to insure prompt handling of the claim.

## NOTICE TO DOCTOR

Forward "Physician's or Surgeon's First Report" to company immediately and attach this "Order on Doctor." Forward "Physician's or Surgeon's Supplementary Report" at two week intervals until the employee is ready to resume work. At termination of the disability period, forward "Physician's or Surgeon's Final Report" including your itemized bill if the employee has been discharged from treatment. These forms may be secured by writing to the nearest office listed below.

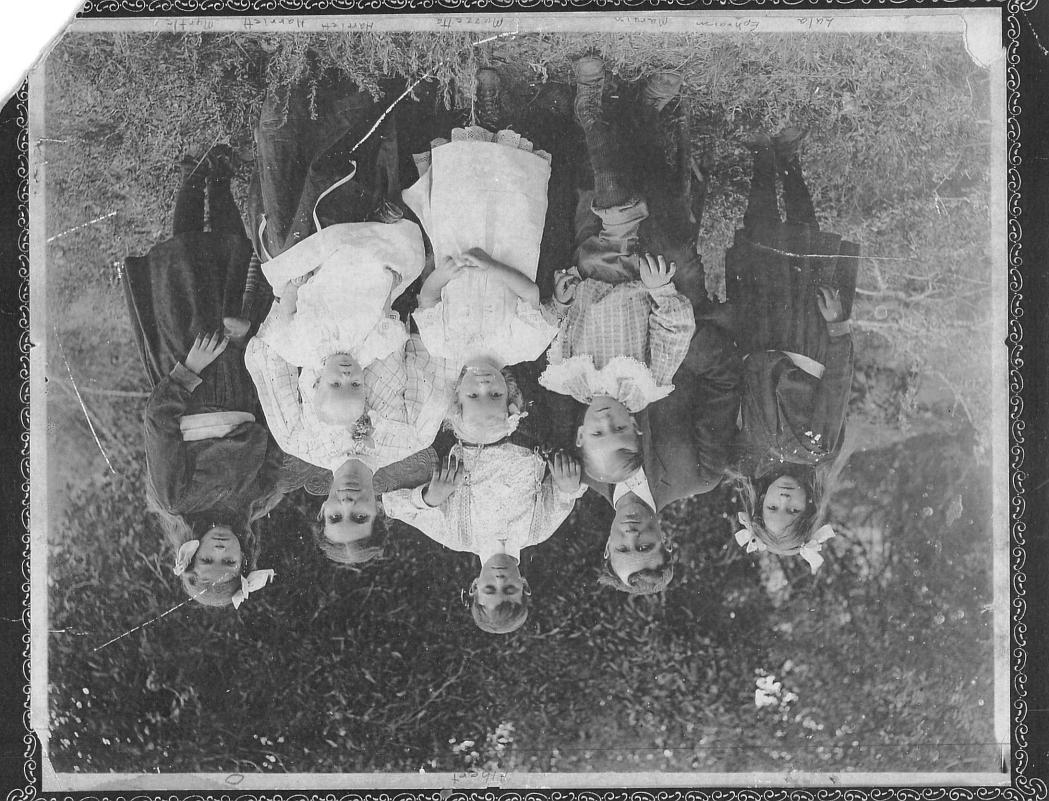
## **Employers Insurance of Wausau**

## EMPLOYERS INSURANCE CLAIM INDEX OFFICES IN THE FOLLOWING CITIES:

ATLANTA, GA.
BALTIMORE, MD.
BELMONT, MASS.
BUFFALO, N.Y.
CHARLOTTE, N.C.
DALLAS, TEX.
DENVER, COLO.
DES MOINES, IA.
DETROIT, MICH.

EAST ORANGE, N.J. EDINA, MINN. HOUSTON, TEX. INDIANAPOLIS, IND. KANSAS CITY, MO. LITTLE ROCK, ARK. LOS ANGELES, CAL. MILWAUKEE, WIS. NEW ORLEANS, LA.

NEW YORK, N.Y.
OMAHA, NEB.
PHILADELPHIA, PA.
PORTLAND, ORE.
RIVER FOREST, ILL.
ST. LOUIS, MO. (CLAYTON)
SAN FRANCISCO, CAL.
SYRACUSE, N.Y.
WAUSAU, WIS.



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